HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

Division of Medicaid and Long-Term Care
Department of Health and Human Services
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INTRODUCTION

The Nebraska Medicaid Health Insurance Premium Payment (HIPP) Program was created in 1994. The purpose of the HIPP Program is to contain costs to the Medicaid program. The HIPP Program pays the private health insurance premiums of individuals who are eligible for and enrolled in Medicaid when Medicaid determines it is cost-effective for the Medicaid Program to pay those premiums. If HIPP is not cost-effective, the individual's eligibility to receive Medicaid coverage is not affected.

Medicaid is the payer of last resort. This means that any other insurance pays for covered benefits for a Medicaid eligible individual before Medicaid is obligated to pay. This is a cost savings to the Medicaid Program. Where the other insurer does not cover a service that is covered by Medicaid, Medicaid continues to provide the coverage. Basically, if the cost of covering a participant's premium is less than the costs Medicaid would have paid in the absence of other insurance coverage, Medicaid's payment of the premium is cost-effective for the Medicaid Program. If the premium is more than the actual or estimated medical costs to Medicaid, then participation in HIPP is not cost-effective for the Medicaid Program.

In May 2013, the Auditor of Public Accounts issued an audit report of the HIPP Program identifying issues with lack of documentation indicating that cost-effectiveness had been determined for HIPP participants and incorrect payments. The HIPP Program was thoroughly reviewed by Medicaid.

REVIEW OF CURRENT HIPP CASES

Medicaid staff reviewed all 455 active HIPP participant files to determine whether it remained cost-effective for Medicaid to continue to pay each participant's health insurance premiums. As of September 17, 2013, 240 participants have been terminated from the HIPP Program because staff made the finding that cost-effectiveness to the Medicaid Program had not been demonstrated.

A Notice of Action was sent to each of these participants informing them of the finding that the documentation available to the Medicaid Program did not indicate payment of the premiums was cost effective. Participants were also provided the opportunity to provide additional documentation to support cost-effectiveness and to appeal the finding by requesting a hearing in the matter.

In some instances, there is no way to ascertain from the Medicaid claims history made available to Medicaid how much the private insurance has paid in claims, absent the participant submitting such information to the program. If providers don't bill Medicaid, then Medicaid does not have records of what the private insurer paid for claims that did not go through the Medicaid system. Two examples are provided below to illustrate the review process and cost-effectiveness decisions:

Participant	Monthly Premium	Annual Premium	Insurance Company Payments based on available information	Savings or (Loss)	Additional Insurance Company payments based on additional documentation provided	Revised Savings or (Loss)	Conclusion based on additional documentation
Example 1	$1,459.48	$17,513.76	$8,690.52	($8,823.24)	$191,960.76	$183,137.52	Cost Effective
Example 2	$3,743.23	$44,918.76	$5,647.18	($39,271.58)	$0.00	($39,271.58)	Not Cost Effective

- In the first example, the available Medicaid claims information indicated the policy was not cost-effective. Additional documentation provided by the participant showed significant payments on claims by the insurance company. Based on this additional information, the policy was found to be cost effective.
- In the second example, the available Medicaid claims information indicated the health insurance policy was not cost-effective. Additional documentation provided by the participant did not change the previous determination. Since the additional information did not indicate payments by the insurance company above the amount previously reported, cost-effectiveness was not substantiated.

The 455 active HIPP participants were also screened to ensure they met all other eligibility requirements beyond cost-effectiveness. All participants (269) that no longer met all eligibility requirements were sent a Notice of Action as described above. The remaining cases (186) were found to be cost-effective based on information already available to the HIPP Program. This review continues today on all new cases, as well as with existing cases on a monthly basis.

The following summarizes the review of the HIPP Program participants, as of September 17, 2013:

- 455 active cases were reviewed for all eligibility requirements and cost-effectiveness.
- 186 of the cases were documented to be cost-effectiveness.
- 240 of the cases were terminated for lack of documentation demonstrating cost-effectiveness.
- 29 of the cases were terminated for other eligibility reasons.
- 75 of the terminated cases were appealed. Of these appealed cases:
    - 34 were resolved prior to hearing. 33 were reversed by HIPP staff based on additional documentation provided by the participant and 1 appeal was withdrawn by the participant.
    - 35 are awaiting a hearing.

- 1 is awaiting decision from the hearing.
- 3 were dismissed when the participant failed to appear for the hearing.
- 2 HIPP determinations were upheld following the hearing.

ADDITIONAL CASE CONSIDERATIONS

Medicaid referred thirteen cases to the DHHS Special Investigations Unit (SIU) to investigate whether participants engaged in fraudulent activities or whether they knowingly received payments in error. Although the SIU inquiries are not yet complete, as of October 4, 2013, SIU has found that, in nine cases, the participants knowingly received payments in error. Medicaid will pursue overpayments in these cases.

In accordance with the state regulations, payments are made directly to the insurance carrier, the employer, or the policyholder in cases of payroll deductions. The method of payment depends on the payment circumstances for each case and is documented in each case. Procedures have been implemented to review all new completed applications within 30 days of their receipt.

PROGRAM IMPROVEMENTS

Concurrent with the effort to remedy deficiencies and ensure compliance with all laws and regulations with respect to active HIPP participants, Medicaid also devoted significant time and effort toward the HIPP Program in general, to ensure compliance with all laws and regulations, improve the day to day operations of the program, improve administrative efficiency, and to ensure that the program represents a cost-savings to the Medicaid Program.

HIPP changes and improvements have been developed and implemented. These improvements include:

- Redesign of HIPP Application and clarification that applications will not be processed until signed and complete which includes required documentation for cost-effectiveness evaluations.
- Creation of new applicant/participant letters to ensure consistency, readability and that all required program documentation is obtained.
- Creation and maintenance of client master list to track applications, participants, appeals, review dates, and other case data.
- Creation of other internal tracking forms to ensure completeness of required case documentation.

HIPP implemented other internal controls to ensure the appropriate management of the program. HIPP implemented a six-month review process to re-verify the premium amount and ongoing other insurance coverage. In addition, each case will be reviewed at twelve months, to not only

include the same review elements as the six-month review, but to ensure receipt of updated documentation and a recalculation of cost-effectiveness. Management will review a portion of all HIPP determinations on a monthly and quarterly basis to ensure ongoing compliance with policies, procedures, and laws and regulations.

HIPP-related duties have been assigned to a Program Specialist who has the primary responsibility for application reviews, calculating cost-effectiveness, Program enrollment, and establishing monthly reimbursement amounts. A Staff Assistant will make payment requests which must be approved by a second individual before payment is made. Additionally, the Program Specialist will monitor and research best practices and trends in other states, laws that impact the HIPP Program, and Program statistics. The Program Specialist will recommend changes, as appropriate, to program procedures, regulations and HIPP Program operations.

In addition to improvements and changes already finalized, additional changes are in progress or in the planning stages. The Division of Medicaid and Long-Term Care is in the process of formalizing Division-wide procedures related to the HIPP Program, such as the initial referral process from the Medicaid eligibility area. Improved access to HIPP-related information and materials is currently being evaluated. To that end, the Division will be developing a web page containing program information and materials for applicants and participants. Such a page will include Frequently Asked Questions, which will help clarify the program for participants and referring parties.

HIPP must operate in accordance with 471 NAC Chapter 30. Chapter 30 is in the process of being redrafted to provide clarification and improve readability. When complete, Chapter 30 will be posted for public hearing in order to receive comments and suggestions as part of the process used to promulgate rules and regulations.

HIPP has not issued IRS Forms 1099 to HIPP participants and will not be implementing changes to the current practice. This issue has been researched with a finding that there is no requirement that Medicaid is required to do so. Additionally, communication from other states with HIPP Programs reflected this same conclusion.

CONCLUSION

In sum, the state of the HIPP Program is greatly improved. Management and staff will continue to seek improvements and stay committed to ensuring compliance with all applicable State and Federal laws and regulations. Current participants are demonstrably cost-effective, and the changes and controls implemented will ensure that the program remains a cost-savings measure for Nebraska Medicaid.